STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155135	A. BUILDING 01 B. WING	07/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health. Survey Date: 07/27/12 Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600 Surveyor: Steve Corya, Life Safety Code Specialist/ICF-IID Surveyor Supervisor At this Quality Assurance Walk-thru survey, Westview Nursing and Rehabilitation Center was found not in compliance with 410 IAC 16.2-3.1-19(ff). This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with battery operated smoke detectors in 43 resident rooms and hard wired smoke detectors in 14	K0000	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Inspection of the newly installed 10-year lithium battery smoke detectors had been completed, but not notated on a clearly identifiable checklist that could be readily identified during the related visit. Those inspections have been identified and included on a clearly identified checklist, plus subsequent monthly inspections. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** This finding was found to possibly affect all residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The clearly identifiable checklist has been implemented and is in use. **How the corrective action(s)**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident rooms. The facility has a capacity of 95 and had a census of 75 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage, however, it was not in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/07/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Maintenance Supervisor has reviewed to ensure the proper and clearly identifiable checklist is being used and will continue to review this monthly for scheduled use. This review has been added to the monthly maintenance schedule. **Compliance date: July 27, 2012**	

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed and maintained to protect the health and safety of residents, personnel and the public. This State Rule has not been met as evidenced by: Based on interview and record review, the facility did not have documentation of a system for maintaining the batteries in the battery powered smoke detectors in 43 of 43 resident rooms. This deficient practice could affect all the residents. Findings include: Interview with the facility maintenance person at 2:45 p.m. on 07/27/12 indicated, "We didn't document the monthly checks of the battery operated smoke detectors. There should be two months worth. The smoke detectors were installed in April of 2012." A review of the facility maintenance records did not produce documentation of a checklist for the battery operated smoke detectors.	K9999	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Inspection of the newly installed 10-year lithium battery smoke detectors had been completed, but not notated on a clearly identifiable checklist that could be readily identified during the related visit. Those inspections have been identified and included on a clearly identified checklist, plus subsequent monthly inspections. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** This finding was found to possibly affect all residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The clearly identifiable checklist has been implemented and is in use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Maintenance Supervisor has reviewed to ensure the proper and clearly identifiable checklist is being used and will continue to review this monthly for scheduled	07/27/2012

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	3.1-19(a)		use. This review has been added to the monthly maintenance schedule. **Compliance date: July 27, 2012**	